AHSQC Quality Improvement Summit

Opioid Reduction Strategies:
How can we use the AHSQC to Help Hernia Surgeons Impact the Opioid Epidemic?

Building a Consensus on Opioid Prescriptions

December 12, 2019
Denver, CO

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Director, UNC Health Care Hernia Center
Assistant Professor, General and Acute Care Surgery
Disclosures

- None
Outline

• Define our goals
• Current AHSQC practices
• Current recommendations
• How did the task force do?
• Recommendations
• Coming to a concensus
Goal

To come to a consensus on how to best manage pain after inguinal and umbilical hernia repair
Poll everywhere

• Text:
  ARIELLEPEREZ936 to 22333 to join the session

• Go to:
  www.PollEV.com/arielleperez936
I'm excited to learn how to improve the care of my hernia patients

That's me!

Definitely not me :( 
Which narcotic medication do you typically prescribe for patients after an inguinal or umbilical hernia repair?

<table>
<thead>
<tr>
<th>I don't prescribe narcotics</th>
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<tr>
<td>hydrocodone</td>
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<td>oxycodone</td>
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<td>dilaudid</td>
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How many tablets of narcotic medication do you typically prescribe for a minimally invasive (laparoscopic or robotic) inguinal hernia?

- >31
- 21-30
- 16-20
- 11-15
- 5-10
- <4
How many tablets of narcotic medication do you typically prescribe for a primary umbilical hernia repair?

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<td>&gt;31</td>
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</table>
How many tablets of narcotic medication do you typically prescribe for an open umbilical hernia repair with mesh?

- >31
- 21-30
- 16-20
- 11-15
- 5-10
- <4
How many tablets of narcotic medication do you typically prescribe for a minimally invasive (laparoscopic or robotic) umbilical hernia repair?

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<tr>
<th>Range</th>
<th>Count</th>
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Current recommendations

• Michigan-OPEN: 0-10 tabs
• Johns Hopkins: 0-15 tabs
• Mayo Clinic: 0-20 tabs
• Dartmouth Hitchcock: 15 tabs
# Michigan- Open

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Oxycodone* 5mg Tablets</th>
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<tr>
<td>Dental Extraction</td>
<td>0</td>
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<td>Thyroidectomy</td>
<td>0 - 5</td>
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<td>Laparoscopic Anti-reflux (Nissen)</td>
<td>0 - 10</td>
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<tr>
<td>Appendectomy – Lap or Open</td>
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<tr>
<td>Laparoscopic Donor Nephrectomy</td>
<td>0 - 10</td>
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<tr>
<td><strong>Hernia Repair – Minor or Major</strong></td>
<td><strong>0 - 10</strong></td>
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Panel: surgeons, pain specialists, outpatient surgical nurse practitioners, surgical residents, patients, and pharmacists

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Range (minimum–maximum)</th>
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<tr>
<td>General surgery</td>
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<tr>
<td>Laparoscopic cholecystectomy (procedure 1)*</td>
<td>0–10</td>
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<tr>
<td>Laparoscopic inguinal hernia repair, unilateral (procedure 2)*</td>
<td>0–15</td>
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<tr>
<td>Open inguinal hernia repair, unilateral (procedure 3)*</td>
<td>0–10</td>
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<tr>
<td>Open umbilical hernia repair</td>
<td>0–15</td>
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</table>
Prospective telephone survey of identified patients

![Diagram showing the amount of opioids prescribed versus used in opioid-naive patients after discharge for 25 elective procedures.]

**FIGURE 1.** Amount of opioids prescribed versus used in opioid-naive patients after discharge for 25 elective procedures.
**Mayo Clinic Surgical Outcomes Program Recommendations for Adult Discharge Opioid Prescriptions**

(# of Tabs of 5 mg Oxycodone or 50 mg Tramadol)

<table>
<thead>
<tr>
<th>General Surgery</th>
<th>Low Dose(^a)</th>
<th>Standard Dose(^b)</th>
<th>High Dose(^c)</th>
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<tbody>
<tr>
<td>Endoscopy (± PEG)</td>
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<td>NSAIDS/Acetaminophen Only</td>
<td>NSAIDS/Acetaminophen Only</td>
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<tr>
<td>Muscle Biopsy or Excisional Biopsy</td>
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<td></td>
<td>3 Tabs Oxycodone or 5 Tabs Tramadol</td>
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<tr>
<td>MIS Cholecystectomy or Appendectomy</td>
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<td></td>
<td>8 Tabs Oxycodone or 12 Tabs Tramadol</td>
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<tr>
<td>MIS Inguinal Hernia Repair (TAPP or TEPP)</td>
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<td></td>
<td>20 Tabs Oxycodone or 30 Tabs Tramadol</td>
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<tr>
<td>Open Inguinal Hernia Repair</td>
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<tr>
<td>MIS Bariatric, Benign Foregut, or Adrenal Surgery</td>
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</table>

Factors shown to influence opioid usage after discharge:
- Opioid Naive
- Older Age, Lower BMI, Longer LOS
- Lower Pain Score at Discharge
- Low-In-hospital Opioid Use

Pre-operative Opioid Users
- Younger Age
- Higher Pain Score at Discharge
- High In-hospital Opioid Use

Author Information

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\(^b\) Surgical Outcomes Program, Robert D and Patricia E Kern Center for the Science of Health Care Delivery, Mayo Clinic, Rochester, MN
Wide Variation and Excessive Dosage of Opioid Prescriptions for Common General Surgical Procedures

Hill, Maureen V. MD; McMahon, Michelle L. BS; Stucke, Ryland S. MD; Barth, Richard J. Jr. MD

Author Information

*Department of Surgery, Dartmouth Hitchcock Medical Center, Lebanon, NH
†Geisel School of Medicine at Dartmouth, Hanover, NH.

Reprints: Richard J. Barth, MD. Section of General Surgery, Department of Surgery, Dartmouth-

Prospective telephone survey of identified patients

![Graphs showing opioid pills prescribed and taken](image)

**FIGURE 3.** Frequency of opioid pills prescribed (A, C) and taken (B, D) after laparoscopic inguinal hernia repair and open inguinal hernia repair.
Is it reasonable to reduce opioid prescribing habits of AHSQC members?

Yes
• Evaluation of current habits of Opioid Reduction Task Force
<table>
<thead>
<tr>
<th>Umbilical Open</th>
<th>Umbilical Lap</th>
<th>Umbilical Robo</th>
<th>Inguinal Open</th>
<th>Inguinal Lap</th>
<th>Inguinal Robo</th>
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<td><strong>Hafner</strong></td>
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<td>• Tylenol 100mg Q6H scheduled x 48hrs, then q6h prn</td>
<td>• Gabapentin 200mg Q8H x 48h</td>
<td>• Gabapentin 200mg Q8H x 48h</td>
<td>• Rx for 5 tabs of tramadol 50mg</td>
<td>• Gabapentin 200mg Q8H x 48h</td>
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<td>Petro</td>
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<tr>
<td>• 12 tabs oxycodone</td>
<td>• 28 tabs oxycodone if going home from PACU, if overnight stay, no formal algorithm</td>
<td>• 28 tabs oxycodone if going home from PACU, if overnight stay, no formal algorithm</td>
<td>• 12 tabs oxycodone</td>
<td>• 12 tabs oxycodone</td>
<td>• 12 tabs oxycodone</td>
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<td>Poulouse</td>
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<td>• 10 tabs oxycodone</td>
<td>• ibuprofen 600mg/acetaminophen 650mg alternating each q3hrs</td>
<td>• ibuprofen 600mg/acetaminophen 650mg alternating each q3hrs</td>
<td>• 10 tabs oxycodone</td>
<td>• 10 tabs oxycodone</td>
<td>• 10 tabs oxycodone</td>
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<td>Perez</td>
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<td>• 10 tabs oxycodone</td>
<td>• Rx ibuprofen 600mg/acetaminophen 650mg alternating each q3hrs (although these can sometimes change if I forget to tell the resident)</td>
<td>• 15 tabs oxycodone</td>
<td>• 15 tabs oxycodone</td>
<td>• 10 tabs oxycodone</td>
<td>• 10 tabs oxycodone</td>
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<td>• ibuprofen 600mg/acetaminophen 650mg alternating each q3hrs (although these can sometimes change if I forget to tell the resident)</td>
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<td>Warren</td>
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<td>First Line: Ibuprofen 800mg TID x 20 pills. Alternate with Tylenol 650 – 1000mg QID x 20 pills* (adjust / remove if narcotic/APAP prescribed)</td>
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<td>Second Line: Based on surgeon discretion OR patient discussion preop</td>
<td>Second Line: Based on surgeon discretion OR patient discussion preop</td>
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<td>Tramadol 50mg q 6 hrs x 8 pills (40 MME) OR Norco 5/325mg q 8 hrs x 8 pills (40 MME) OR Oxycodeine 5mg q 8 hrs x 6 pills (45 MME)</td>
<td>Tramadol 50mg q 6 hrs x 15 pills (75 MME) OR Norco 5/325mg q 8 hrs x 15 pills (75 MME) OR Oxycodeine 5mg q 8 hrs x 10 pills (75 MME)</td>
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<td>• 6 tabs oxycodone</td>
<td>• Tylenol and Motrin q6h together for 2-5 days postop.</td>
<td>• Tylenol and Motrin q6h together for 2-5 days postop.</td>
<td>• 10 tabs oxycodone (shouldicis)</td>
<td>• 6 tabs oxycodone (open posterior mesh)</td>
<td>• Tylenol and Motrin q6h together for 2-5 days postop.</td>
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<td>Hafner</td>
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<td>Perez</td>
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- **Rx for 5 tabs of tramadol 50mg**
November trial with AHSQC Opioid Task Force

Pilot trial to evaluate efficacy based on current practice models

- Prescribe 10 or less tablets of narcotic (Oxycodone, Vicodin, Tramadol, Dilaudid, etc)
- Prescribe or recommend acetaminophen and NSAID when possible
- Educate our patients that opioids are a rescue medication, and about the side effects
- Provide patients the educational handout from the AHSQC
- Track our prescribing methods and patient reported outcomes
Opioid Educational Trifold Handout

SAFE STORAGE AND DISPOSAL
Store opioids out of sight and reach of children, teens, and pets.
- Share opioids in private areas and lock up your pills if possible.
- Do not store your opioids in common areas like bathrooms or in purses.
- Keep a count of how many pills you have left.

Dispose of all unused opioids:
- Use a permanent medication drop box.
- To find one near you, visit https://apps.dea.gov/pubdisposal/.
- Check off at a community pharmacy. Take back event.
- Use your household trash as a last resort.
- Mix opioids in a coffee ground or kitty litter into a plastic bag and throw away.
- Scratch out personal information on the prescription bottle and dispose of the original container.

DO NOT flush opioids down the toilet.

LEARN THE FACTS: opioids & pain management

UNDERSTANDING PAIN AFTER SURGERY
The goal of pain management is to manage your pain enough to allow you to do the things you need to do in order to heal: walk, eat, breathe easily and sleep.

Pain expectations:
- Severe pain after surgery is normal.
- Pain is usually worst for the first 2-3 days after surgery.
- Your pain may be well controlled with a schedule of over-the-counter medications.
- Pain medication is only one part of your pain management plan.

Other things you can do to help manage pain:
- Mindful breathing
- Music
- Physical therapy
- Relaxation
- Daily reflection
- Short walks

USING OPIOIDS SAFELY

BEFORE SURGERY:
- Ask your surgeon if you can use over-the-counter acetaminophen (Tylenol) or ibuprofen (Motrin or Advil) for your pain, before using opioids.
- Tell your surgeon if you are currently taking any sedatives or benzodiazepines (like Valium or Xanax).

AFTER SURGERY:
- If you are still in a lot of pain after taking an over-the-counter pain medicine, use the opioid medicine your surgeon gave you.
- Do not mix opioids with alcohol, benzodiazepines (like Valium or Xanax), muscle relaxers, or other medications that can cause sleepiness.
- As your pain gets better, wait longer between taking opioids.
- Only use the opioids for your surgical pain. Do not use your opioids for other reasons.
- Talk to your surgeon if you are having trouble managing your pain.

If your pain is manageable, do not use your opioids.

KNOW THE RISKS
You are at higher risk of developing a dependence or addiction to opioids if you:

HAVE A HISTORY OF:
- Abusing alcohol, prescription, or recreational drugs
- Using tobacco
- Depression, anxiety, or other mood disorders
- Long-term (chronic) pain

TAKE OPIOIDS MORE OFTEN THAN YOUR SURGEON PRESCRIBED

You are at risk of an OVERDOSE if you:

HAVE A HISTORY OF:
- Sleep apnea
- Other breathing problems

TAKE OPIOIDS WITH:
- Alcohol
- Benzodiazepines (like Valium® or Xanax®)
- Muscle relaxers
- Any medications that can cause drowsiness

TAKE OPIOIDS MORE OFTEN THAN YOUR SURGEON PRESCRIBED

DO NOT USE YOUR OPIOIDS WITH OTHERS.
Diversion (sharing or selling) of opioids is a felony.

Michigan-OPEN.org

AHS/QC

AMERICAS HERNIA SOCIETY QUALITY COLLABORATIVE

You are the most important member of your healthcare team. Ask questions and get the facts before taking opioids to manage your pain.
Opioid Reduction Initiative

The opioid epidemic in the United States has become a leading cause of death. As a result of vigorous research, we now know that approximately one in sixteen patients provided a prescription after surgery will become a chronic user of opioids. This chronic use, combined with the fact that only 3 in 10 pills prescribed are used by the intended recipient, has resulted in the fact that one in 3 opioid-related deaths can be attributed to prescription pain killers.

As hernia surgeons, we are committed to partnering with our patients to:

- Set realistic expectations about postoperative pain and pain management
- Reduce opioid prescribing
- Reduce opioid consumption
- Measure outcomes related to hernia surgery and opioid use.

We are committed to continuous quality and process improvement and are providing our patients an informational brochure that should be read carefully by anyone who is given a prescription for opioid analgesics after hernia surgery.

The brochure: "Learn the Facts: opioids & pain management" sets forth the medical community’s developing concern about opioid use. The brochure presents medically accepted information about opioid use, but is general in nature and should not be understood as making any claim concerning the diagnosis, treatment, cure, or prevention of any disease or condition of any particular person. You should consult with your doctor about your need for opioids and your experience and concerns with opioids prescribed by your doctor.

In addition to this brochure, we appreciate your help by completing the Patient reported outcome survey before and after surgery.

References:

2. Chad M. Brummett, MD; Jennifer F. Wolje, MPH; Jenna Goedling, PhD; Stephanie Moser, PhD; Paul Lin, MS; Michael J. Englesbe, MD. New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults. JAMA Surg. 2017;152(5):459-461. doi:10.1001/jamasurg.2017.0044
Preoperative/Postoperative Assessment
Opioid Pain Use

**POSTOPERATIVE ASSESSMENT**

1. How many tablets of prescription opioid pain medication did you take in the past 30 days?
   - 0
   - 1 to 2
   - 3 to 4
   - 5 to 10
   - 11 to 15
   - 16 to 30
   - 30 or more
   - I Prefer not to Answer

<table>
<thead>
<tr>
<th>In the past 7 days...</th>
<th>Had no pain</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very Severe</th>
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<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<th>How intense was your pain at its worst?</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
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</table>

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<tr>
<th>How intense was your average pain?</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tr>
<th>What is your level of pain right now?</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
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</table>
How did we track this in the AHSQC?
How did we track this in the AHSQC?

In 3 spots

– Pre-op Evaluation
– 30 Day Follow up
– Patient Reported Outcomes
Pre-operative Evaluation

### Opioid Use

- **Show opioid detail questions?** *
  - Yes
  - No

### Function Status and Employment/Activities

- **Employment Type** (Click for descriptions from the OSHA website): *Unknown*

- **Sporting Activity** (Required for inguinal disruption/core muscle injury, athletic pubalgia, or sports hernia): *Unknown*
Preoperative Opioid Use

- Opioid Use

- Behavioral health history (CATA): check all that apply *
  - Major depression
  - Anxiety disorder
  - Other psychiatric
  - None

- Opioid/substance use history (CATA): check all that apply *
  - Recent opioid use (within 30 days)
  - Chronic use of provider-prescribed opioid analgesic medication (>90 days)
  - Chronic use of non-provider prescribed opioid analgesic medication (>90 days)
  - Other substance use
  - None
30 Day Follow Up
Patient Reported Outcomes
Patient Reported Outcomes

Patient Reported Outcomes - Inguinal

(If you do not wish to complete this survey or submit any of your responses, click QUIT.)

Please share information that your doctor would need to know regarding your hernia (or hernia surgery) so that he/she can take the best care of you.

To add a NEW timepoint, click the + icon at the upper right. If you get a generic error check timepoint has not already been entered.

Contact

Method of completion
- In-person visit
- Phone
- Obtained from medical record (abstraction)

Follow up

Patient Reported Outcomes Timepoint (select the closest timepoint) *

Choose only one

Opioid Use

How many tablets of prescription opioid pain medication did you take in the past 30 days? *

0
1 to 2
3 to 4
5 to 10
11 to 15
16 to 30

Answering questions in the 3 main fields of:
- Pain
- Quality of life
- Return to work or usual activities

because of pain or discomfort.
How did the task force do?

• No call backs from patients for additional opioid prescriptions

• Some difficulty with entering data

• Still working through various struggles
Tips to entering data

• Petro: MA enters the 30-day postop as well as the PRO that the patients fill out in the office prior to the postop visit. Has standardized prescribing to 6 tablets per case, except in unusual cases. The MA’s look at the EMR to confirm

• Iocca: “I have my office staff enter the 30d post op and PRO while waiting for the visit postop. We too standardize rx for motrin, tylenol and 10 tabs of tramadol unless unusual case and I ask on post op what was taken, also look at quick discharge summary.”

• Reinhorn: “I made data collection part of my MA's and PA's job description, or it would not happen - we are too busy. We also have patients fill out pre and post surgery PRO at every visit - even the ones that don't get surgery.”
Struggles

• Prescriptions varied due to prescriber

• Data not completely obtained or entered

• Data is difficult to find in EMR

• Lack of motivation with extra clicks
SUCCESS IS BORN OF STRUGGLE
Struggles

• Prescriptions varied due to prescriber
  Standardized prescriptions reduce variability

• Data not completely obtained or entered
  Standardized workflow – assign time/person to input data

• Data is difficult to find in EMR
  Learn the EMR. Once you know, it’s easier to find

• Lack of motivation with extra clicks
  Take pride in knowing that you’re helping your patients
Best Practices

• Preop evaluation
  • Patients to fill out preoperative PRO form and data filled into AHSQC

• Periperative
  • Discuss pain expectations and discuss medications in preop holding
  • Discuss and provide first line therapy: Tylenol, Ibuprofen, etc
  • Provide AHSQC opioid education handout with discharge instructions
  • Standardized narcotic Rx

• Follow up
  • Patient to fill out preoperative PRO form and data filled into AHSQC
Can we come to a consensus for opioid prescriptions?

- Proposal:
  - Adopt an agreed upon maximum number of tablets for typical inguinal and umbilical hernia repairs (this can be adjusted for outlier patients)
  - Surgeons will implement this into practice and input data into the AHSQC
  - Outcomes data will be reevaluated in 6-12 months to determine if any modifications should take place
Proposed reasonable opioid prescription

Based on AHSQC data and outside institutional guidelines:

10 or less tabs for inguinal hernia repair

10 or less tabs for umbilical hernia repair
Vote
Are you willing to commit to lowering opioid abuse in the healthcare system?

yes

No
How many tablets of narcotic medication is reasonable to prescribe after a typical inguinal hernia (open, laparoscopic, and/or robotic)?

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<tr>
<td>5 or less</td>
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<tr>
<td>10 or less</td>
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<tr>
<td>20 or less</td>
<td></td>
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<tr>
<td>30 or less</td>
<td></td>
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<tr>
<td>I don't think we should standardize this</td>
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</table>
How many tablets of narcotic medication do you think it is reasonable to prescribe for a typical umbilical hernia repair (primary, with mesh, laparoscopic, and/or robotic)?

- 5 or less
- 10 or less
- 20 or less
- 30 or less
- I don't think it should be standardized
BE THE CHANGE

“Somewhere we must make it clear that we are concerned about the survival of the world.”

Dr. Martin Luther King, Jr.